FOLLOW-UP FORM

☐ **FACE to FACE** ☐ **home** ☐ **office** ☐ **other** ☐ **TELEPHONE**

Follow-up contact with ☐ **Client** ☐ **Parent/Guardian**

Name: _____ DOB: _____ Medicaid Number: _____

Follow-up number:
☐ One ☐ Two ☐ Three ☐ Four ☐ Five ☐ Six ☐ Seven ☐ Eight ☐ Nine ☐ #_____

Summary of follow-up contact (include only one billable contact—non-billable services must be documented on progress note).

☐ Service plan reviewed and updated with client/parent/guardian according to policy.

Are case management services to continue?

☐ Yes, time frame for next billed follow-up visit _____

☐ Yes, prior authorization required for additional visits Date requested:_____

☐ No, case closed Date closed: _____
referral(s) made at time of closure: ☐ no referrals needed

_____

☐ No, case transferred to: _____ Date transferred: _____

Case manager signature: _____ Date: _____

Case manager printed name: _____